Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 OF DALLAS
SUITE 1000
9330 LBJ FREEWAY
DALLAS TX 75243

Respondent Name
ARCH INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-1776-01

MFDR Date Received
March 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied per EOB services denied at the time authorization/pre-certification was requested. CPT code 90806 was preauthorized, #9889532. Please refer to the attached authorization letter for further review."

Amount in Dispute: $140.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The attached EOBs raise preauthorization issues. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). The carrier challenges whether the disputed charges are consistent with applicable fee guidelines.

Response Submitted by: FLAHIVE OGDEN & LATSON

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 4, 2012	90806	$140.59	$132.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 39 – Services denied at the time authorization/pre-certification was requested.
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt request, submit a copy of this EOR or clear notation that a rec

Issues

1. Did the requestor obtain preauthorization for the disputed service?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   Review of the preauthorization letter submitted by the requestor dated September 28, 2012 issued by Coventry Workers' Comp Services documents that the requestor obtained preauthorization for mental health therapy 1xWkx6Wks, 6 visits date of service 09/25/12-11/24/12, preauthorization number 9889532.

   As a result, the disputed service was preauthorized and will be reviewed for payment pursuant to 28 Texas Administrative Code §134.203.
2. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   The requestor seeks reimbursement in the amount of $140.59, the MAR reimbursement for CPT code 90806 is $132.94, this amount is recommended.

   Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT code 90806 in the amount of $132.94

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $132.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $132.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).